		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003103

Facility Name: Memorial Convalescent Center

Address: 4315 Memorial Dr (Number) Belleville (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: (618) 233-7750 **Fax #** (618) 257-6839

IDPA ID Number: 37-0635502-002

Date of Initial License for Current Owners: 03/01/64

Type of Ownership:

[x]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Eleanor Benton **Telephone Number:** (618) 257-5603

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 04/22/2002 (Date)
(Type or Print Name) Anne B Crook
(Title) Asst. Administrator & Asst. Director of Nursing

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,991		20,817	24,808	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,991		20,817	24,808	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.93%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/03/64

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 108 and days of care provided 8,018

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	356,789	2,400		359,189		359,189	273,812	633,001			1
2	Food Purchase		255,274		255,274		255,274		255,274			2
3	Housekeeping	122,330	12,419		134,749		134,749	38,658	173,407			3
4	Laundry		79,786		79,786		79,786	45,244	125,030			4
5	Heat and Other Utilities			84,291	84,291		84,291		84,291			5
6	Maintenance	39,083	19,236		58,319		58,319	881	59,200			6
7	Other (specify):*											7
8	**TOTAL General Services**	518,202	369,115	84,291	971,608		971,608	358,595	1,330,203			8
	B. Health Care and Programs											
9	Medical Director					12,115	12,115		12,115			9
10	Nursing and Medical Records	2,135,193	113,029	28,052	2,276,274	(189)	2,276,085	49,170	2,325,255			10
10a	Therapy	459,430	21,657		481,087		481,087	182,604	663,691			10a
11	Activities	72,401	3,182		75,583		75,583		75,583			11
12	Social Services	57,844			57,844		57,844	55,637	113,481			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Disp Diapers**		50,668		50,668		50,668	(21,363)	29,305			15
16	**TOTAL Health Care and Programs**	2,724,868	188,536	28,052	2,941,456	11,926	2,953,382	266,048	3,219,430			16
	C. General Administration											
17	Administrative	61,686			61,686	(12,115)	49,571		49,571			17
18	Directors Fees											18
19	Professional Services			10,267	10,267		10,267		10,267			19
20	Dues, Fees, Subscriptions & Promotions			5,541	5,541		5,541		5,541			20
21	Clerical & General Office Expenses	119,970		17,728	137,698	(1,234)	136,464	(10,346)	126,118			21
22	Employee Benefits & Payroll Taxes			641,738	641,738		641,738	90,084	731,822			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			49,507	49,507		49,507		49,507			26
27	Other (specify):* **Bad Debts**			56,130	56,130		56,130	(56,130)				27
28	**TOTAL General Administration**	181,656		780,911	962,567	(13,349)	949,218	23,608	972,826			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,424,726	557,651	893,254	4,875,631	(1,423)	4,874,208	648,251	5,522,459			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Memorial Convalescent Center #0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			105,456	105,456		105,456	101,077	206,533			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			105,456	105,456		105,456	101,077	206,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	71,349	208,890	1,064	281,303		281,303	77,272	358,575			39
40	Barber and Beauty Shops					1,423	1,423		1,423			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,130	59,130		59,130		59,130			42
43	Other (specify):*	58,320	41,902	10,105	110,327		110,327	54,541	164,868			43
44	**TOTAL Special Cost Centers**	129,669	250,792	70,299	450,760	1,423	452,183	131,813	583,996			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,554,395	808,443	1,069,009	5,431,847		5,431,847	881,141	6,312,988			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,792)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,411)	6		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(56,130)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,333)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	950,474		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 950,474		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 881,141		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops	x		1,423	10	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,423		47

STATE OF ILLINOIS

Memorial Convalescent Center

ID# 0003103

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	273,812	0	0	0	0	0	0	0	0	0	273,812	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	38,658	0	0	0	0	0	0	0	0	0	38,658	3
4	Laundry	0	45,244	0	0	0	0	0	0	0	0	0	45,244	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,411)	2,292	0	0	0	0	0	0	0	0	0	881	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,411)	360,006	0	0	0	0	0	0	0	0	0	358,595	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	49,170	0	0	0	0	0	0	0	0	0	49,170	10
10a	Therapy	0	182,604	0	0	0	0	0	0	0	0	0	182,604	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	55,637	0	0	0	0	0	0	0	0	0	55,637	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(21,363)	0	0	0	0	0	0	0	0	0	(21,363)	15
16	**TOTAL Health Care and Programs**	0	266,048	0	0	0	0	0	0	0	0	0	266,048	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	(10,346)	0	0	0	0	0	0	0	0	0	(10,346)	21
22	Employee Benefits & Payroll Taxes	0	90,084	0	0	0	0	0	0	0	0	0	90,084	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(56,130)	0	0	0	0	0	0	0	0	0	0	(56,130)	27
28	**TOTAL General Administration**	(56,130)	79,738	0	0	0	0	0	0	0	0	0	23,608	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(57,541)	705,792	0	0	0	0	0	0	0	0	0	648,251	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Memorial Convalescent Center # 0003103 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(11,792)	112,869	0	0	0	0	0	0	0	0	0	101,077	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(11,792)	112,869	0	0	0	0	0	0	0	0	0	101,077	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	77,272	0	0	0	0	0	0	0	0	0	77,272	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	54,541	0	0	0	0	0	0	0	0	0	54,541	43
44	**TOTAL Special Cost Centers**	0	131,813	0	0	0	0	0	0	0	0	0	131,813	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(69,333)	950,474	0	0	0	0	0	0	0	0	0	881,141	45

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Memorial Hospital	Belleville	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	Employee Benefits	$ 641,738	Memorial Hospital	0.00%	$ 731,822	$ 90,084	1
2	V	21	Administration	136,464			126,118	(10,346)	2
3	V	6	Maintenance	58,319			60,611	2,292	3
4	V	4	Laundry	79,786			125,030	45,244	4
5	V	3	Housekeeping	134,749			173,407	38,658	5
6	V	1	Dietary	359,189			633,001	273,812	6
7	V	15	Central	50,668			29,305	(21,363)	7
8	V	39	Pharmacy ,medical supplies	281,303			358,575	77,272	8
9	V	43	Ancillary services	110,327			164,868	54,541	9
10	V	12	Social service	57,844			113,481	55,637	10
11	V	10	Medical records	1,234			50,404	49,170	11
12	V	10a	Therapy	481,087			663,691	182,604	12
13	V	30	Depreciation	105,456			218,325	112,869	13
14	Total			$ 2,498,164			$ 3,448,638	$ * 950,474	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	Not Applicable										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Memorial Hospital
Street Address: 4500 Memorial Drive
City / State / Zip Code: Belleville,Il 62226
Phone Number: (618) 233-7750
Fax Number: (618) 257-6839

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Salaries	60,512,390	2	$ 18,459,035	$ 567,866	2,207,594	$ 673,417	1
2	21	Communications	Phones	975	2	557,845	184,976	6	3,433	2
3	21	Data Processing	Resources	10,000	2	1,781,215	662,510	75	13,359	3
4	21	Materials Management	Stores Requisitions	4,269,584	2	637,324	404,473	76,269	11,385	4
5	21	Administration	Accumulated Cost	124,698,559	2	8,493,143	2,764,558	3,124,776	212,827	5
6	6	Plant	Square Feet	18,453	1	165,883	39,083	16,119	144,902	6
7	4	Laundry	Pounds	2,550,339	2	998,866	374,705	319,230	125,030	7
8	3	Housekeeping	Square Feet	121,760	2	2,413,679	1,469,674	72	1,427	8
9	3	Housekeeping MCC	Square Feet	17,705	2	188,902	122,330	16,119	171,980	9
10	1	Dietary	Patient Meals	267,353	2	3,190,947	1,381,274	74,424	888,275	10
11	22	Emp Ben/Cafeteria	Employee Meals	133,133	2	1,111,604	884,523	6,995	58,405	11
12	10	Medical Records	Time Spent	10,000	2	2,964,967	1,572,970	170	50,404	12
13	12	Social Service	Time Spent	114,058	2	698,403	440,802	18,533	113,482	13
14	43	Radiology	Revenue	28,347,887	2	7,815,705	2,386,707	66,784	18,413	14
15	43	Laboratory	Revenue	46,950,215	2	10,943,668	3,456,483	383,163	89,312	15
16	43	Nutritional Support	Revenue	520,665	2	386,386	183,676	61,090	45,335	16
17	43	EKG	Revenue	12,963,529	2	2,663,844	966,652	57,462	11,808	17
18	39	Drugs & IV Therapy	Revenue	17,439,273	2	8,306,247	1,669,761	651,005	310,071	18
19	39	Medical Supplies Sold	Revenue	2,883,704	2	4,290,881	584,640	52,292	77,809	19
20	10a	Respiratory Care	Revenue	11,321,650	2	2,860,326	1,524,413	229,133	57,889	20
21	10a	Physical Therapy	Revenue	10,289,912	2	4,772,780	2,433,794	828,263	384,174	21
22	10a	Occupational Therapy	Revenue	1,113,849	2	423,891	262,199	533,662	203,093	22
23	10a	Speech Therapy	Revenue	148,823	2	110,416	61,939	24,982	18,535	23
24	30	Capital Cost	See Attached	13,000,799	2	13,000,799	0	218,325	218,325	24
25	TOTALS					$ 97,236,756	$ 24,400,008		$ 3,903,090	25

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2				Not Applicable								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Memorial Convalescent Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0003103

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,365 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1964	$ 40,000	1
2					2
3	TOTALS			$ 40,000	3

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		1964	1964	$ 882,395	$ 9,957	33.3	$	$ (9,957)	$ 882,395	4
5			1966	1966	144,150	838	30.89		(838)	144,150	5
6			1979	1979	237,657	1,644	20.28	1,644		216,593	6
7			1980	1980	2,695					2,695	7
8			1981	1981	18,583					18,583	8
	Improvement Type**										
9											9
10	Electrical Upgrade			1996	25,549	1,360	18.79	1,360		7,479	10
11	Walking Track			1998	7,690	513	15	513		1,796	11
12	Roof Replacement			1998	68,383	6,838	10	6,838		23,933	12
13	Change in electrical power system			1998	5,479	365	15	365		1,277	13
14	7 1/2 ton A/C unit			1998	14,326	955	15	955		3,343	14
15	Air furnace			1998	15,226	1,015	15	1,015		3,553	15
16	5 ton air handler			1998	14,900	993	15	993		3,476	16
17	Electrical work-boiler rm,A/C unit,relamp,auto tr switch			1998	91,162	4,558	20	4,558		15,953	17
18	Air handling unit installed			1994	12,048	803	15	803		6,023	18
19	Repair parking lot			1994	83,569	7,702	10.85	7,702		57,760	19
20	Landscaping			1994	4,200	280	15	280		2,100	20
21	Flooring replaced in patient room			1993	56,883	3,793	15	3,793		32,233	21
22	Activity Therapy Renovation			1993	41,940	2,265	12.83	2,265		24,276	22
23	Condensing unit			1993	4,684	312	15	312		2,652	23
24	Air conditioners			1993	6,589	439	15	439		3,732	24
25	Upgrade lighting			1993	4,516	226	20	226		1,921	25
26	Renovate patient room & nurse station			1992	42,370	2,324	17.99	2,324		22,383	26
27	Renovate patient rooms-doors,wallcovering,bldg			1992	75,908	721	10.49	721		71,947	27
28	Roof top air conditioner			1992	4,342	290	15	290		2,751	28
29	Renovate business office			1991	35,387	1,865	18.5	1,865		21,925	29
30	Patient rooms-drywall,ceiling,paint			1991	39,835	2,423	14.55	2,423		28,425	30
31	Demolish back lounge			1991	752	50	15	50		525	31
32	Brickwork chimney			1991	5,225	349	15	349		3,655	32
33	Paint exterior tower			1991	1,185		5			1,185	33
34	ITE Panel			1991	995	50	20	50		525	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air conditioner	1991	$ 6,580	$ 439	15	$ 439	$	$ 4,604	37
38	Telephone wiring	1991	924	46	10	46		921	38
39	Circuit breaker	1991	1,011	50	20	50		529	39
40	Cubicles & track	1990	9,899		5			9,899	40
41	Half Glass door windows	1989	601	40	15	40		500	41
42	Roofing	1988	55,463		10			55,463	42
43	Air conditioner	1988	1,556		5			1,556	43
44	Air conditioner	1987	1,551		5			1,551	44
45	Remove bathroom showers	1987	17,966	483	15.56	483		15,409	45
46	Cooling units	1986	3,854		9			3,854	46
47	Cooling units	1985	5,644		10			5,644	47
48	Resurface road	1985	39,780		15			39,780	48
49	Guttering	1985	2,116		20			2,116	49
50	Metal door frames	1984	5,751	287	20	287		5,030	50
51	Water & Sewer lines	1984	2,807	141	20	141		2,451	51
52	Sprinkle system	1978	27,578	1,103	25		(1,103)	27,578	52
53	Sprinkle system	1977	1,585		20			1,585	53
54	Cooling unit & heat detectors	1974	5,468					5,468	54
55	Air conditioners & beauty shop	1973	1,210					1,210	55
56	Heating & cooling equipment	1972	53,944					53,944	56
57	Smoke detector	1971	5,800					5,800	57
58	Land Improvements	1968	4,238		40	106	106	3,657	58
59	Vinyl flooring restrooms	1999	2,441	488	5	488		1,220	59
60	Reznor make up air unit	1999	15,432	1,543	10	1,543		3,858	60
61	Electrical work	1999	2,566	128	20	128		320	61
62	New door physical therapy	2000	3,735	249	15	249		374	62
63	Porch columns	2000	5,965	398	15	398		597	63
64	Repair walls	2001	2,080	69	15	69		69	64
65	Electrical work	2001	4,191	105	20	105		105	65
66	Electrical work	2001	16,778	419	20	419		419	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,257,137	$ 58,916		$ 47,124	$ (11,792)	$ 1,864,755	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 345,454	$ 33,399	$ 33,399	$	10.3	$ 251,105	71
72	Current Year Purchases	12,616	848	848		7.4	848	72
73	Fully Depreciated Assets	157,924					157,924	73
74								74
75	TOTALS	$ 515,994	$ 34,247	$ 34,247	$		$ 409,877	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2000 Ford Bus	2000	$ 49,174	$ 12,293	$ 12,293	$	4	$ 18,440	76
77										77
78										78
79										79
80	TOTALS			$ 49,174	$ 12,293	$ 12,293	$		$ 18,440	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,862,305	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,456	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 93,664	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,792)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,293,072	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$ 27,356	$	$ 27,356	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 27,356	$	$ 27,356	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$ 167,417		$	$ 5,763		$ 173,180	1
2	Licensed Speech and Language Development Therapist		hrs	9,921			1,491		11,412	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs	250,599			4,665		255,264	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts	71,349			208,890		280,239	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 499,286		$	$ 220,809		$ 720,095	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,014	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	492,764		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,875		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 521,653	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,132,204		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	565,168		16
17	Accumulated Depreciation (book methods)	(2,260,124)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements	152,289		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 629,537	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,151,190	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 93,143	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,569		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 225,712	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserve for Self Insurance	310,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 310,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 535,712	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 615,478	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,151,190	$	48

***(See instructions.)**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 758,152	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 758,152	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(371,217)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (371,217)	17
	B. Transfers (Itemize):		
18	**Interfund Transfer - Hospital**	228,543	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 228,543	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 615,478	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,341,157	1
2	Discounts and Allowances for all Levels	(1,172,470)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,168,687	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,386,907	6
7	Oxygen	229,133	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,616,040	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,423	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	651,005	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	383,163	19
20	Radiology and X-Ray	66,784	20
21	Other Medical Services	171,907	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,274,282	23
	D. Non-Operating Revenue		
24	Contributions	210	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 210	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Chapel Maintenance	1,411	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,411	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,060,630	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	971,608	31
32	Health Care	2,941,456	32
33	General Administration	962,567	33
	B. Capital Expense		
34	Ownership	105,456	34
	C. Ancillary Expense		
35	Special Cost Centers	281,303	35
36	Provider Participation Fee	59,130	36
	D. Other Expenses (specify):		
37	Nutritional Support,Lab,X-ray,EKG	110,327	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,431,847	40
41	**Income before Income Taxes (line 30 minus line 40)****	(371,217)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (371,217)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	538	620	$ 24,083	$ 38.84	1
2	Assistant Director of Nursing	1,763	2,096	59,941	28.60	2
3	Registered Nurses	26,611	28,970	675,643	23.32	3
4	Licensed Practical Nurses	10,299	10,894	191,947	17.62	4
5	Nurse Aides & Orderlies	71,627	77,243	891,185	11.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,291	5,805	72,401	12.47	10
11	Social Service Workers	2,904	3,146	57,844	18.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,821	37,461	356,789	9.52	15
16	Dishwashers					16
17	Maintenance Workers	3,304	3,588	39,083	10.89	17
18	Housekeepers	11,328	12,755	122,330	9.59	18
19	Laundry					19
20	Administrator	1,349	1,557	46,726	30.01	20
21	Assistant Administrator					21
22	Other Administrative	38	42	2,845	67.74	22
23	Office Manager					23
24	Clerical	25,127	27,645	411,130	14.87	24
25	Vocational Instruction	8,118	8,925	167,417	18.76	25
26	Academic Instruction					26
27	Medical Director	99	107	12,115	113.22	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	98	105	1,234	11.75	31
32	Other Health Care(specify)					32
33	Other(specify)	19,808	22,512	421,682	18.73	33
34	TOTAL (lines 1 - 33)	222,123	243,471	$ 3,554,395 *	$ 14.60	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	49	21,667		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Physician Advisor	65	7,200		46
47	Psychologist	12	1,215		47
48	Physician Reviewer	36	2,135		48
49	TOTAL (lines 35 - 48)	162	$ 32,217		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	6,065	96,317	Ln 10,col1	52
53	TOTAL (lines 50 - 52)	6,065	$ 96,317		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Ann Hagler	Admin.Assistant	0	$ 46,726
Joe Lanius	V.P.-Finance	0	1,511
Terry Walther	V.P.-Rehab	0	1,334
Dr. William Sutherland	Medical Director	0	12,115
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 61,686

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Daniel J Mulvanny	Legal Fees	$ 1,140
PricewaterhouseCoopers	Audit Fees	4,980
AAA Credit	Collection Fees	4,147
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 10,267

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Health Care	5,541
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,541

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2	NOT APPLICABLE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Il. Health Care $5,541**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.4**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,305** Line **15**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **58,406** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,001,545**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Not Applicable**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD,LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.